James Skoumal, D.D.S. PC.

1 South 132 Summit Ave, Suite 201 Oakbrook Terrace, Illinois 60181

Financial Agreement

- 1. I agree to pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family or to the patient indicated at time of service.
- 2. On accounts past due 60 days or more, I agree to ay the doctor a CARRYING CHARGE computed at the periodic rate allowable by law in the state of Illinois...

Monthly Periodic Rate 1.5% on past due balances (60 days)
Annual Percentage Rate 18%
This CARRYING CHARGE will only be applied to balances over 60 days old, after deducting current charges and payments.

- 3. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I understand that my insurance is an agreement between my insurance company and myself. I also understand that I am responsible for the balance of my dental account regardless of insurance.
- 4. I can avoid incurring a CARRYING CHARGE by paying my account balance in full upon receipt of statement provided that payment is actually received by the Doctor before the next billing date. This allows for a minimum of 60 days from the date of service to pay my account without incurring a CARRYING CHARGE.
- 5. If it is necessary for the doctor to retain an outside service to collect any balance due, I will be responsible for all collection costs, attorney fees and court costs.
- 6. I understand that there will be a charge for any check that is returned.

DECLARATION

I have read the Financial Agreement printed on this form, and I have copy of this Financial Agreement.	received a fully complete
Responsible Party or Authorized Member of the Family	Date

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HIPAA

Health Insurance Portability and Accountability Act

The law covers a wide range of issues, including:

- assuring portability of health insurance coverage
- a fraud and abuse control program
- creating medical savings accounts
- administrative simplifications provisions, such as privacy

Our dental office falls under the **PRIVACY STANDARDS** portion of the regulations because we transmit some health insurance information (insurance claims) electronically.

Part of the regulations require that we provide you with the accompanying form (**NOTICE OF PRIVACY PRACTICES**) and ask that you acknowledge that we have given the **NOTICE** to you for review by signing and dating the **ACKNOWLEDGEMENT** form.

The information basically tells you that we will not use your health information for any marketing purposes without your express permission. It goes on to describe your rights as a patient, namely:

- the right to access and copy your dental records
- the right to amend the information in your dental records
- the right to an accounting of non-routine or non-authorized disclosures
- the right to complain to our office or to the Secretary of Health and Human Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement				
I,	, have received a copy of this office's			
Please Print Patient's Name				
Signature (if under 18 years of age, must be signed by parent or legal guardian) Date				
For Office Use Only				
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:				
 Individual refused to sign Communications barrier prohibited obtaining the acknowled An emergency situation prevented us from obtaining acknowled 	•			

MEDICAL HISTORY

Patient Name:		Birth Date:			
Preferred Name:					
Health problems that y	you may have, or med	lication th	at you m	•	outh is a part of your entire boo e an important interrelationship as.
•	<u>. </u>	<mark>questions,</mark>	please p	provide more informati	on to the right of the question.
Are you under a physic If so, please list their number.		O Yes	O No		
Have you ever been ho major operation?	ospitalized or had a	O Yes	O No		
Are you taking any medications, pills, or drugs? Please list medications		O Yes	O No		
Do you take, or have you taken, Phen-Fen or Redux?		O Yes	O No		
Have you ever taken For Reclast, Actonel or any containing bisphospho	other medications	O Yes	O No		
Are you on a special di	et?	O Yes	O No		
Do you have a Neurolo Add/Depression/MS)	ogic Condition (Ex:	O Yes	O No		
Do you use tobacco?		O Yes	O No		
Are you allergic to any			\sim	A 1:	001:
O Aspirin	O Metal			Acrylic	O Codeine
O Ibuprofen	O Latex			O Local Anesthetics O Acetaminophen	
O Penicillin	O Sulta Drug	O Sulfa Drugs		O No Known Allergies	
If any other allergy, ple	ease list:				
Women: Are you					

-Please fill out back as well-

 ${\bf O}$ Taking oral contraceptives

O Nursing

O Pregnant/Trying to get pregnant

HEART/HEMATOLOGY RESPIRATORY O Diabetes (List HbA1c: O ALDS/HIV O Alos/HIV O Alos/HIV O Diabetes (List HbA1c: O ALDS/HIV O Cold Sores/Fever Blisters O Bload Diases/Disorder O Bload Diases/Disorder O Hay Fever O Hypoglycemia O Hypog	Do you have, or have you had, any of the following? If yes, please describe in the Additional Information Box.					
A Artificial Heart Valve Disease	HEART/HEMATOLOGY	RESPIRATORY	ENDOCRINE	INFECTIONS		
O Artificial Heart Valve O Blood Disease/Disorder O Brown Disease/Disorder O Brown Disease/Disorder O Bruse Easily O Congental Heart Disorder O Excessive Bleeding O Fainting/Syncope/ Dizziness O Heart Attack/Failure O Heart Murmur O Heart Attack/Failure O Heart Trouble/Disease O Hemophilia O Infective Endocarditis O Irregular Heartbat O Low Blood Pressure O High Blood Pressure O Since Disorder O Since Disorder O Jigestive Disorder O Jigestive Disorders O Jinestone O Jigestive Disorder O Jigestive Disorders O Jornsillitis O Tuberculosis O Celiac/Castric Reflux) O Stomach/Intestinal Disease O Jinetive Endocarditis O Irregular Heartbeat O Low Blood Pressure O Sickle Cell Disease O Siroke O Stroke O Stroke O Stroke O Stroke O Read Additional Information: List any serious illness not mentioned on this page: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X		O Anaphylaxis	O Diabetes (List HbA1c:	O AIDS/HIV		
O Blood Disease/Disorder O Blood Transfusion O Bruise Easily O Congenital Heart Disorder O Excessive Bleeding O Fainting/Syncope/Diziness O Heart Attack/Failure O Heart Attack/Failure O Heart Stent O Heart Trouble/Disease O Heart Trouble/Disease O Heart Trouble/Disease O Heart Trouble/Disease O Heart Stent O Heart Bood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat D Low Blood Pressure O Stroke O Digestive Disorders O Reand Dialysis O Cancer/ Tumors/ Growths O Cancer/ Tumors/ O Recent Weight Loss O Mental Handicap O Pressure O Anxiety (Dental or Other) O Stroporosis/ O Stroke O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Steoporosis/ O Steop	O Angina, Chest Pains	O Asthma)	O Cold Sores/Fever		
O Bruise Easily O Congenital Heart Disorder O Excessive Bleeding Fainting/Syncope/ Dizziness O Heart Attack/Failure O Heart Murmur O Heart Trouble/Disease O Heart Trouble/Disease O Heart Trouble/Disease O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Isow Blood Pressure O Mitral Valve Prolapse O Stroke O Stroke O Swelling of Limbs To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. V Material Care O High Cholesterol O Stroke O Heard Strok O Stroke O Heard Strok O Stroke O Heard Trouble/Disease O Heard Trouble/D	O Artificial Heart Valve	O Breathing Problem	O Glaucoma	Blisters		
O Bruise Easily O Congenital Heart Disorder O Excessive Bleeding O Fainting/Syncope/ Dizziness O Heart Attack/Failure O Heart Pacemaker O Heart Trouble/Disease O Heart Stent O Hempshilia O High Blood Pressure O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mirral Valve Prolapse O Sirckle Cell Disease O Stroke Nethritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Recent Weight Loss O Stroke O Steeporosis/ O Steeporosis	O Blood Disease/Disorder	○ Emphysema	O Hormone Deficiency	O Hepatitis (Specify Type		
O Congenital Heart Discase O Liver Disease/ Jaundice O Hives/Rash O Sinus Trouble O Sleep Disorder O Sleep Disorder O Soring O Thyroid Disease O Shingles O Stroke O St	O Blood Transfusion	O Hay Fever	O Hypoglycemia	in Comments)		
Disorder Excessive Bleeding O Sinus Trouble O Siepp Disorder O Salend Disorder O Siepp Disorder O Digestive Disorders O Digestive Disorders O Cellac/Gastric Reflux) O Stomach/Intestinal Disease O Ulcers O Digestive Disorders O Chemotherapy/ Immunosuppression O Recent Weight Loss O Frequent Headaches O Preychatric Care O Anxiety (Dental or Other) O Stroke O Swelling of Limbs Distal Disease O John Pain Disease O John Pain Disease O Ulcers O Frequent Diarrhea O Jaw Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Disease O John Pain Dis	O Bruise Easily	O Lung/ Respiratory	O Kidney Problems	O Herpes		
O Excessive Bleeding O Fainting/Syncope/ Dizziness O Heart Attack/Failure O Heart Murmur O Heart Murmur O Heart Trouble/Disease O Heart Trouble/Disease O High Blood Pressure O High Cholesterol O Sinders O Sind Diagestive Disorders (Celiac/Gastric Reflux) O Uclers O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Sickle Cell Disease O Sickle Cell Disease O Stroke O Stroke O Swelling of Limbs Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Y Date: Disease O Singles O Thyroid Disease O Tonsillitis O Tuberculosis O Tuberculosis O Touslionis O Cancer/ Tumors/ Growths O Cancer/ Tumors/ Growths O Cancer/ Tumors/ Growths O Cancer/ Tumors/ Growths O Renal Dialysis O Touslionis O Cancer/ Tumors/ Growths O Renal Dialysis O Tuberculosis O Cancer/ Tumors/ Growths O Cancer/ Tumors/ Growths O Renal Pages O Tuberculosis O Tuberculosi	O Congenital Heart	Disease	O Liver Disease/ Jaundice	O Hives/Rash		
O Fainting/Syncope/Dizzness O Heart Attack/Failure O Heart Murmur O Heart Murmur O Heart Pacemaker O Heart Trouble/Disease O Hemophilia O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Stroke O Tumors/ O Cancer/Tumors/ O Rediation treatments O Prequent Dearchea O Pressure O High Cholesterol O Julers O Frequent Diarrhea O Jaw Pain O Stroke O Jarthritis/Gout/Lupus O Arthritis/Gout/Lupus O Attrictial Joint O Cortisone Medicine O Head or Neck Injury O Steepoprosis/ O Steoporosis/ O	Disorder	O Sinus Trouble	O Parathyroid Disease	O Rheumatic/ Scarlet		
Dizziness O Heart Attack/Failure O Heart Attack/Failure O Heart Stent O Heart Stent O Heart Frouble/Disease O Heart Trouble/Disease O Heart Trouble/Disease O Heart Trouble/Disease O Heart Frouble/Disease O Ulcers O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Sickle Cell Disease O Sickle Cell Disease O Stroke O Stroke O Stroke O Heart Frequent Headaches O	O Excessive Bleeding	○ Sleep Disorder		Fever		
O Heart Attack/Failure O Heart Murmur O Heart Stent O Heart Trouble/Disease O Heart Trouble/Disease O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Sickle Cell Disease O Stroke O Swelling of Limbs To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. DIGESTIVE O NOCLOGY O Tuberculosis O Toutslorit O Cancer/Tumors/ Growths O Cancer/Tumors/ O Chemotherapy/ Immunosuppression O Radiation treatments O Prequent Headaches O Prequent Headaches O Mental Handicap O Presyntiatric Care O Anxiety (Dental or Other) Other) List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	○ Fainting/Syncope/	○ Snoring	O Thyroid Disease	○ Shingles		
Heart Murmur	Dizziness			○ STD		
O Heart Pacemaker O Heart Stent O Heart Trouble/Disease O Heart Trouble/Disease O Hemophilia O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Stroke O Stroke O Stroke O Swelling of Limbs Corrisone Medicine O Head or Neck Injury O Steoppenia O Rheumatism Comments and Additional Information: DIGESTIVE O J Cancer/Tumors/ Growths O Cancer/Tumors/ O Chemotherapy/ Immunosuppression O Radiation treatments O Recent Weight Loss O Mental Haadicap O Prequent Headaches O Mental Handicap O Prequent Headaches O Anxiety (Dental or Other) O Arthritis/Gout/Lupus O Arthritis	O Heart Attack/Failure			○ Tonsillitis		
O Heart Stent O Heart Trouble/Disease O Hemophilia O High Blood Pressure O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Sickle Cell Disease O Stroke O Swelling of Limbs Disease O Johns O Stomach/Intestinal Disease O Julcers O Jav Pain Disease O Julcers O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) O Steve Cell Disease O Artificial Joint O Cortisone Medicine O Head or Neck Injury O Osteoporosis/ O Steopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Disease O Chemotherapy/ Immunosuppression O Radiation treatments O Mead theratheat O Mead the Medicine O Peccent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) O Psychiatric Care O Anxiety (Dental or Other) O Psychiatric Care O Anxiety (Dental or Other) O Stenoporosis/ O Steoporosis/ O Steop				Tuberculosis		
O Heart Trouble/Disease O Hemophilia O Hemophilia O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Stroke O Stroke O Swelling of Limbs Disease O Stroke O Swelling of Limbs Corrisone Medicine O Head or Neck Injury O Osteoporosis/ Osteopenia O Rheumatism List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. O Clemotherapy/ O Chemotherapy/ Immunosuppression O Chemotherapy/ O Radiation treatments O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) O Anxiety (Dental or Other) O Stroke O Stroke O Stroke O Swelling of Limbs List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: Disease O Ulcers O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Steopenia O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) O Stroke O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Stroke O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Arthritis/Gout/Lupus O Stroke O Arthritis/Gout/Lupus O Arthritis/Gout/Lupu	O Heart Pacemaker	DIGESTIVE	ONCOLOGY	MENTAL HEALTH		
O Hemophilia O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Stroke O Stroke O Swelling of Limbs O Steopenia O Redemants and Additional Information: Comments and Additional Information: Comments and Additional Information in the dental office of any changes in medical status. O Steopenia O To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	O Heart Stent	O Digestive Disorders	O Cancer/ Tumors/	O Alzheimer's Disease		
O High Blood Pressure O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Sickle Cell Disease O Stroke O Swelling of Limbs Disease O Ulcers O Hadation treatments O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) Other) List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Disease O Ulcers O Radiation treatments O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) Other) Distance O Stroke O Stroke O Arthritis/Gout/Lupus O Arthritis/Gout/L	O Heart Trouble/Disease	(Celiac/Gastric Reflux)	Growths	O Drug Addiction		
O High Cholesterol O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Sickle Cell Disease O Stroke O Swelling of Limbs Cortisone Medicine O Head or Neck Injury O Osteopensia O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date:	•	○ Stomach/Intestinal	O Chemotherapy/	O Epilepsy/ Seizures/		
O Infective Endocarditis O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Sickle Cell Disease O Stroke O Swelling of Limbs O Arthritis/Gout/Lupus O Head or Neck Injury O Osteoporosis/ O Steopenia O Recent Weight Loss O Mental Handicap O Psychiatric Care O Anxiety (Dental or Other) List any serious illness not mentioned on this page: Comments and Additional Information: Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date:	_	Disease	Immunosuppression	Convulsions		
O Irregular Heartbeat O Low Blood Pressure O Mitral Valve Prolapse O Stroke O Stroke O Swelling of Limbs Iswalling of Limbs JOINTS O Arthritis/Gout/Lupus O Artificial Joint O Cortisone Medicine O Head or Neck Injury O Steopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date: Date:	_	O Ulcers	O Radiation treatments	• Frequent Headaches		
O Low Blood Pressure Mitral Valve Prolapse Sickle Cell Disease Stroke Swelling of Limbs O Arthritis/Gout/Lupus Artificial Joint Cortisone Medicine Head or Neck Injury O steopenia Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date: Date:		O Frequent Diarrhea	O Recent Weight Loss	Mental Handicap		
O Mitral Valve Prolapse Sickle Cell Disease Stroke O Stroke O Swelling of Limbs O Arthritis/Gout/Lupus O Artificial Joint O Cortisone Medicine Head or Neck Injury O Steopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date: Date:	_	O Jaw Pain		O Psychiatric Care		
Sickle Cell Disease Stroke Stroke Swelling of Limbs Stroke St				• Anxiety (Dental or		
O Stroke O Swelling of Limbs O Artificial Joint O Cortisone Medicine O Head or Neck Injury O Osteopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date: Date:	-			Other)		
O Swelling of Limbs O Artificial Joint O Cortisone Medicine Head or Neck Injury O Osteoporosis/ Osteopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X		JOINTS	List any serious illness not m	entioned on this page:		
Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X						
O Head or Neck Injury O Osteoporosis/ Osteopenia O Rheumatism Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X	Swelling of Limbs	• Artificial Joint				
Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X						
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Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X		1				
Comments and Additional Information: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X		<u> </u>				
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X		O Rheumatism				
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. X						
incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date:	Comments and Additional Ir	nformation:				
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incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Date:						
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inform the dental office of any changes in medical status.	To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing					
X Date:	incorrect and/or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to					
	inform the dental office of any changes in medical status.					
	X Date:					
	Signature of Patio					

James Skoumal, D.D.S. PC.

1 South 132 Summit Ave, Suite 201 Oakbrook Terrace, Illinois 60181

REGISTRATION AND HEALTH HISTORY

Today's Date		Date of Bir	rth	
Patient Name	Prefer	rred Name		
Home #	Cell #		SS#	
Home Address		City	Sta	ate Zip
Email Address				
Ok to receive elect	ronic communication Text () Em	nail ()		
Martial Status: Mine	or () (Parents' Names)			
Mar	ried () (Spouse's Name)			
Sing	le () Separated () Divorced () Widow ()	Widower ()	
Whom may we that	nk for referring you to our office?			
Patient's Employer			Phone	
or Father's if	Address			
patient is minor	City		State	_ Zip
Occupation	SS#		_ Drivers License #	<u></u>
Dental Insurance	es() No() Insured name and	date of birth		
	I hereby authorize payment of the directly, to Dr. James Skoumal, D	D.D.S. PC.		me
	Signed (Insured Person)		Date	
Patient's Employer			Phone	
or Mother's if	Address			
			State	_ Zip
Occupation	SS#		_ Drivers License #	<u> </u>
Dental Insurance	es () No () Insured name and (date of birth		
	I hereby authorize payment of the directly, to Dr. James Skoumal, D		otherwise payable to	me
	Signed (Insured Person)		 Date	
	•			

Emergency Contact Name_____ Relation____ Phone #____